CMS ILLINOIS Rod R. Blagojevich, Governor
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES
Michael M. Rumman, Director

APPLICATION FORM

Contingent Lump Sum Incentive Program

APPLICATIONS POSTMARKED OR DELIVERED BEFORE OCTOBER 4, 2004, WILL BE NOT BE PROCESSED.

PLEASE PRINT OR TYPE THE INFORMATION REQUESTED BELOW.

1. Name: _____ SSN: _____-_____-_____
LAST FIRST MI

Home
Address: _____ DOB: _____

_____ Contact #: ( ) _____-_____
CITY STATE ZIP

2. Name of Agency: _____ Vacation Earning Date:_____
(Obtain from Current Employing Agency)

Agency Address: _____ Agency Contact #: ( ) _____-_____

_____
CITY STATE ZIP

I wish to participate in the Contingent Lump Sum Incentive Program. I hereby resign my employment effective

_____, contingent upon my application for participation in the Program being approved.
(**MUST** insert a date from Nov. 1, 2004 through Dec. 31, 2004)

_____ _____
Applicant's Signature Date

APPLICATIONS **MUST** CONTAIN AN **ORIGINAL** SIGNATURE. **INCOMPLETE APPLICATIONS WILL BE DENIED.** THIS FORM MUST BE SENT BY US MAIL TO THE SPRINGFIELD ADDRESS BELOW OR HAND DELIVERED TO EITHER LOCATION; APPLICATIONS **WILL NOT** BE ACCEPTED BY FACSIMILE.

Return To:

Contingent Lump Sum Incentive Program
CMS, Bureau of Personnel
503 Stratton Office Building
401 South Spring
Springfield, IL 62706
US Mail or Hand Delivery

or

Contingent Lump Sum Incentive Program
CMS, Bureau of Personnel
James R. Thompson Center
100 W. Randolph, Suite 3-300
Chicago, IL 60601
Hand Delivery ONLY

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